

Child History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name: _____ Today's Date: _____

Parent(s) Name: _____

Sibling(s) Name(s) (Ages): _____

Address: _____ City: _____ Prov. _____

Postal Code: _____ Home Phone: (____) _____ Bus Phone: (____) _____

Date of Birth: _____ Age: ____ Gender: M F Referred by: _____

Email address: _____

Has your child ever received chiropractic care? Yes No If yes, previous DC's name and last visit date?

Name of Medical Doctor: _____

Date of last MD visit and reason: _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S): _____ WORK TEL: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____

Present Health Complaints/Concerns:

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem: Occasional Frequent Constant Intermittent

Does problem radiate? Yes No If yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No If yes, when? _____

Does this interfere with the child's Sleep? Eating? Daily Routine?

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

Family Health History

Please note any health problems (cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family _____

Father's family _____

Sibling(s) _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss Of Taste | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Fevers | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Radiating Pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Reduced Mobility |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Numbness in Leg(s) |
| <input type="checkbox"/> Loss of Concentration | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Numbness in Feet |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Numbness in Hand(s) |
| <input type="checkbox"/> Ears Buzzing | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Ear Pain / Infections | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Constipation | <input type="checkbox"/> Allergies | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Bloating / Gas | |
| <input type="checkbox"/> Other: _____ | | | |

History of Birth

What was the child’s gestational age at birth? _____ weeks.

Was your child born Cephalic (head first) Breech (feet first)

Were there any complications during the birth? Yes No If yes, please explain _____

Please check any assistance that was used during the birth:

- Forceps Vacuum Extraction C-Section Episiotomy

Was labour Spontaneous Induced

Were medications or epidurals given to the mother during birth? Yes No if yes, what was given? _____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (falls, accidents, etc.) Yes No If yes, please explain _____

Any evidence of birth trauma to the infant?

- | | | |
|---|---|---|
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Odd Shaped Head | <input type="checkbox"/> Stuck in Birth Canal |
| <input type="checkbox"/> Fast or Excessively Long Birth | <input type="checkbox"/> Respiratory Depression | <input type="checkbox"/> Cord Around Neck |

Any falls from couches, beds, change tables, etc? Yes No If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches, or fractures? Yes No If yes, please explain _____

Any hospitalizations or surgeries? Yes No If yes, please explain _____

Any sports played? _____

Is a school backpack used? Yes No If yes, is it Heavy Light

Information you believe is important on the child that has not been asked: _____